INDIANA PRIOR REVIEW AND AUTHORIZATION REQUEST

(# REQUIRED IF MEDICAID PROVIDER) PMP ( )

Requesting Provider # _____ Phone _____

Name _____

Address _____

City/State/ZIP _____

Rendering Provider # _____ Phone _____

Name _____

Address _____

City/State/ZIP _____

INTERNAL USE ONLY

(1) HOME HEALTH
(2-3) HOSP., OUT PT
(4) PHYSICIAN
(5) REHAB.
(6) TRANSPLANT
(7) TRANSPORTATION
(8) AUDIOLOGY
(9) SPEECH
(10) MENTAL HEALTH SERVICES
(11) DURABLE MEDICAL EQUIPMENT
(12) OCCUPATIONAL THERAPY (OT)
(13) PHYSICAL THERAPY (PT)
(14) RESPIRATORY THERAPY (RT)
(15) DENTAL SERVICES
(16) OPTOMETRIC SERVICES (OD)
(17) PODIATRY SERVICES
(18) CHIROPRACTIC SERVICES
(19) PHARMACEUTICAL SERVICES

PCCM ( ) MCO ( ) 590 ( )

RID No. _____ DOB _____

Name _____

Address _____

City/State/ZIP _____

MEDICAL DIAGNOSIS: (USE OF ICD-9-CM DIAGNOSTIC CODE REQUIRED)

Primary _____

Secondary _____

Is this a request for continuing service? Yes ☐ No ☐ (No gap in certification) ☐

Will DME be: Purchased: ☐ Rented: ☐ Repaired: ☐ Length of time DME required: _____

Has service or medical supply been previously provided? Yes ☐ Date _____ No ☐

WARNING: ANY AUTHORIZATION IS VALID ONLY IF THE MEMBER IS ELIGIBLE ON THE DATE SERVICE WAS PROVIDED.

DATES OF SERVICE START MMDDCCYY	DATES OF SERVICE STOP MMDDCCYY	SERVICE CODE (REQUIRED)	MODIFIER (S)				REQUESTED SERVICE	TAXONOMY	POS	UNITS	DOLLARS

Clinical Summary: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Home Health, and Transportation) must be attached.

Signature of Requesting Provider _____ Date _____

(original signature required) The above sections must be completed or the request will be rejected.

FORWARD TO:
HCE Prior Authorization Department
P.O. Box 531520
Indianapolis, IN 46253-1520

Date of Submission _____